# EXHIBIT “E-1”

## Affidavit of Edward E. Meier, M.D.

w/ Medical Records Attached

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ROME DIVISION

| | | |
|---|---|---|
| **DAVID R. WILSON and CHARLENE WILSON,** | : | |
| **Plaintiffs,** | : | |
| | : | **CIVIL ACTION** |
| **V.** | : | **FILE NO. 4:06-CV-179-HLM** |
| **TASER INTERNATIONAL, INC.,** | : | |
| **Defendant.** | : | |

**AFFIDAVIT OF EDWARD E. MEIER, M.D.**

Personally appeared before me, an officer duly authorized to administer an oath, **EDWARD E. MEIER, M.D.**, who, after being sworn, states the following:

1.

My name is Dr. Edward E. Meier. I am of age, competent to make this Affidavit, and do so based upon my personal knowledge. Attached to this Affidavit are the medical records of David Wilson.

2.

I am a Board Certified physician specializing in Occupational Medicine and Family Practice. I obtained my medical degree from the University of South Florida in June of 1979. In 2000, I obtained my Masters of Public Health in Occupational Medicine at the Medical College of Wisconsin.

3.

On September 8, 2004, Mr. David Wilson appeared at my office stating that he had sustained a back injury the day before when he was shot by a TASER as part of a training exercise. He was seen at the emergency room in Forsyth, Georgia. Upon examination of Mr. Wilson on that date, I found that he was suffering severe back pain, including tenderness and bilateral spasms. His back showed a loss of lordosis and excessive kyphosis. I gave him a Toradol shot, prescribed Vioxx and Flexeril, and continued him on the Hydrocodone which he had been prescribed at the ER.

4.

I next saw Mr. Wilson on September 10, 2004. He was somewhat improved, but still having a lot of back spasms with a limited range of motion secondary to the spasms. I gave him another Toradol shot, and recommended physical therapy, limited duty at work, and that he continue on his medications.

5.

I next saw Mr. Wilson on October 5, 2004. He was improved, but still experiencing tenderness in his back. He had been going to physical therapy. I continued him on his medications, and recommended work hardening to see if he could return to regular duty.

6.

Mr. Wilson returned to the office on October 28, 2004, and was seen by Dr. Michael Jackson, my partner in our practice. Dr. Jackson noted that Mr. Wilson had been placed into work hardening, but was unable to comply with the regimen. Mr. Wilson was unable to hold a one pound weight out at any distance from his body, or to lift his arms in an arc above his head at physical therapy. On examination, he had excellent grip strength bilaterally with his arms in close, which diminished as his arms were extended. He complained of pain over the left subscapular and latissimus area. He had some findings on the right, but not to the same degree as the left. Dr. Jackson recommended a thoracic spine MRI and work restrictions, including no climbing, occasional sitting, standing, bending, driving; no over the head work; limited repetitive work; zero to ten pound weight restriction; and follow up once the MRI was done. Dr. Jackson changed his medication from Flexeril to Norflex.

7.

Mr. Wilson returned to the office on November 16, 2004, following his MRI on November 9, 2004. An MRI is the standard medical procedure for diagnosing compression fractures. The MRI showed a T6 and T8 wedge compression fracture of his vertebral spine. The fracture was described by the radiologist as "mild relatively acute appearing wedge compression deformities of the T6 and T8

vertebral with some probable surrounding soft tissue hematoma." Mr. Wilson was referred to Dr. Scott Bowerman, an orthopedic for further evaluation. I subsequently had several phone consultations with Dr. Bowerman.

8.

Based upon my review of the records from the Monroe County Hospital Emergency Room, the records from physical therapy, the radiologist report, Dr. Bowerman's consultation, and my treatment of Mr. Wilson which began the day following his injury and continued for more than two months afterward, and based upon my professional training and experience, and to a reasonable degree of medical certainty, the cause of Mr. Wilson's compression fracture and his severe back pain was due to exposure to the TASER during the training exercise on September 7, 2004. It has been documented in the medical literature that fractures may be caused by electrical shock.

**FURTHER AFFIANT SAITH NOT.**

**EDWARD E. MEIER, M.D.**

Sworn to and Subscribed
Before Me this 24th day
Of July, 2007.

Notary Public

VANESSA M. MEACHEM NOTARY PUBLIC WHITFIELD COUNTY, GEORGIA COMMISSION EXPIRES JUNE 12, 2008

David Wilson
DOB 01/19/1957

11/16/04 (Jackson)

Date of Injury: 09/07/2004
Diagnosis: Upper back strain.

S: He states he feels about the same. Mr. Wilson underwent an MRI, which showed a T6 and T8 wedge compression fracture of his vertebral spine. It was felt to be acute with hematoma by the radiologist. He has been taking intermittent Norflex and Lorcet with Tylenol as he needs it.

O: He is still tender when he holds his arms out straight. Generally he is still tender about the mid upper back. His pain has not changed appreciably since the last visit. Considerable time was spent with him discussing the findings of the MRI, with the thoracic fractures at T6 and T8.

A/P: We are going to go ahead and refer him to orthopedics for evaluation of his thoracic fractures. I refilled his Ibuprofen today at 800 mg t.i.d., which I instructed him to take daily, whether he "needs it or not," as we are treating inflammation. I explained to him that likely he will hurt for another one to two months, at which point the pain should just resolve. I would not anticipate that this will turn into a long protracted course. Also, I recommend he make an appointment to see his family practice doctor in evaluation of the osteoporosis that may have been underlying in his condition. He will likely need blood and Dexa work-up for the osteoporosis/osteopenia. He said that he would follow-up on that. We will await the results of his orthopedic consultation. The patient was strongly reassured that this pain will not be continuing and should resolve without difficulty over the coming couple of months.

MJ/ATI040

Michael Jackson

**Redmond Occupational Health**

# RETURN TO WORK FORM


Redmond FCC at Lindale
3138 Maple Road
Lindale, GA 30147
706-290-5000

Redmond FCC at Rockmart
2293 Rome Highway
Rockmart, GA 30153
770-684-0350

Redmond FCC at Shannon
5865 New Calhoun Highway, N.E.
Shannon, GA 30172
706-295-1184

Redmond FCC at Trion
160 Central Avenue
Trion, GA 30753
706-734-7302

Redmond FCC at East Rome
715 E. 2nd Avenue
Rome, GA 30161
706-235-1102

Redmond FCC at West Rome
2304 Shorter Avenue
Rome, GA 30165
706-233-4000

Redmond Internal Medicine at Cedartown
188 E. Girard Avenue
Suite 104
Cedartown, GA 30125
770-749-1005

Redmond Emergency Center
501 Redmond Road
Rome, GA 30165
706-291-0291

Polk Medical Emergency Center
242 N. Main Street
Cedartown, GA 30125
770-748-2500


## Employer Information

Date: 11-16-04 ☐ Drug Screen ☐ Breath Alcohol Date of Injury: 9-7-04

Employee Name: David Wilson SSN: _____

Company: GA State Patrol Department: _____

Authorized by: _____ Title: _____ Time: _____

Telephone: _____ Fax: _____ Pager: _____

Description of Injury: _____

FAX 404-656-9178

Employee sent to: Redmond Family Care Center at West Rome
2304 Shorter Avenue
Rome, GA 30165

## Physician Information

Diagnosis: T6-T8 Compression fracture Time In 9:00 (AM) PM

Treatment/Medications: Aleve 800 TID; Protonix 40; Norflex, Lorcet

Estimated Return to Work Date: today

**Work Status:**

- ☐ No Restrictions As of: _____
- ☐ See Physicial Capabilities Below From: _____ To: _____
- ☐ Bed Rest From: _____ To: _____
- ☐ MMI Achieved As of: _____

2-3 wks.
**Re-check Date:** _____

- ☐ No Follow-up Needed
- ☐ Workers' Comp Panel MD ortho.
- ☒ Specialist: Dr. Bowerman
  Date: _____ Time: _____
- ☐ Physical Therapy (RRMC-P.T.)
  Date: _____ Time: _____
- ☐ X-Ray / MRI / C.T.
  Date: _____ Time: _____
  Location: _____

**PHYSICAL CAPABILITIES:**

| In an 8-12 hour work day, employee can: | Constantly (67-100%) | Frequently (33-66%) | Occasionally (0-33%) | Not at All |
|---|---|---|---|---|
| Climbing | ☐ | ☐ | ☐ | ☑ |
| Stand/Walk | ☐ | ☑ | ☐ | ☐ |
| Sit | ☐ | ☑ | ☐ | ☐ |
| Drive | ☐ | ☑ | ☐ | ☐ |
| Bend | ☐ | ☐ | ☑ | ☐ |
| Squat | ☐ | ☐ | ☑ | ☐ |
| Twist | ☐ | ☐ | ☑ | ☐ |
| Perform Work at Shoulder Level | ☐ | ☐ | ☑ | ☐ |
| Perform Repetitive Motions | ☐ | ☑ | ☐ | ☐ |
| Perform Overhead Work | ☐ | ☐ | ☑ | ☐ |

11/16/04 DSP

Employee is able to lift no more than: ☑ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: Needs to see orthopedist.

Physician Signature: Michael D Jackson Date: 10/28/04

Time Out: 940 (AM) PM

WMR 00004

DMS 53016573 (R 12/03)

David Wilson
DOV: 10/28/04 (Jackson)
DOB: 1/19/57

S: Mr. Wilson is a 47-year-old male state trooper who was shot with a taser on 9/7/04. His description of the injury from what he remembers is that his hips shot forward and his torso and shoulders shot backwards. He was caught by two spotters and laid to the ground gently. He did not fall. After laying there disoriented a couple of minutes he was unable to get up. When he did finally manage to stand up his disorientation continued along with pain in his back. He noticed that the other people in the group that had been shot were not reacting the same way. He sat down he said for 10-15 minutes and then lost circulation in his hands and feet. Paramedics came and evaluated him. He has been to physical therapy and massage therapy which he says feels good but he can't tell that it is doing much. He also was placed into work hardening and is really unable to comply with the regimen. He tells me that as long as he keeps his arms close to his body he is able to perform most tasks however if he has to extend his arms or work overhead he is simply unable to do it. He tells me today that he had trouble holding the 1 lb weight out at any distance and lifting them in an arc above his head at physical therapy. He has noted encroachment into his daily life. He has difficulty lifting a 25 lb bag of dog food from the shelf into his grocery cart and from the grocery cart into the truck. He has been unable to do any kind of yard work and finds even dressing himself difficult with trying to put a shirt over his head. He worked one week but was fearful driving the patrol car that he would be unable to protect himself if he was involved in an altercation from a wrestling standpoint. He did not feel he would be adequately confident to use or handle his firearm secondary to being unable to hold it up.

O: On exam today he has excellent grip strength bilaterally with his arms in close. This diminishes as his arms are extended. He complains of some pain primarily over the left subscapular and latissimus area. He has some findings on the right as well but not to the same degree as to the left. He stated that when he actually tried to work after standing for about 10 hours on alternate duty he had pain in the left serratus area of his musculature as well. Really has not had any findings suggestive of lumbar. Still has intact reflexes in the upper extremity.

A: Thoracic muscle strain. Although it has now been approximately seven weeks since his injury and with the failed PT and work hardening I am recommending that we go ahead and get an MRI of his thoracic spine.

MJ

(Jackson)

P: He is to return for reevaluation after the thoracic spine MRI is done. Work restrictions, no climbing, occasional sitting, standing, bending, driving. No over the head work. Limited repetitive work and 0-10 lb weight restriction. He is to follow up with us once the MRI is done. I did treat him today with Norflex one p.o. t.i.d. as he said the Flexeril he was given previously was ineffective.

MJ/ATI017

11-1-04 SD

**Redmond Occupational Health**

Redmond FCC at Lindale
3138 Maple Road
Lindale, GA 30147
706-290-5000

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Rome, GA 30165
706-291-0291

Polk Medical Emergency Center
242 N. Main Street
Cedartown, GA 30125
770-748-2500

# RETURN TO WORK FORM

## Employer Information

Date: 10-28-04 ☐ Drug Screen ☐ Breath Alcohol Date of Injury: 9-7-04

Employee Name: David Wilson SSN: _____

Company: GA State Patrol Department: _____

Authorized by: _____ Title: _____ Time: _____

Telephone: _____ Fax: _____ Pager: _____

Description of Injury: _____

Employee sent to: Redmond Family Care Center at West Rome
2304 Shorter Avenue
Rome, GA 30165

## Physician Information

Diagnosis: upper back strain

Time In 10:10 (AM) PM

Treatment/Medications: Lorcet; Norflex

Re-check Date: after MRI

☐ No Follow-up Needed

☐ Workers' Comp Panel MD

☐ Specialist: Dr. _____
Date: _____ Time: _____

☐ Physical Therapy (RRMC-P.T.)
Date: _____ Time: _____

☑ X-Ray / MRI / C.T.
Date: _____ Time: _____
Location: _____

Estimated Return to Work Date: 10/28/04

**Work Status:**

☐ No Restrictions As of: _____

☒ See Physicial Capabilities Below From: _____ To: _____

☐ Bed Rest From: _____ To: _____

☐ MMI Achieved As of: _____

**PHYSICAL CAPABILITIES:**

| In an 8-12 hour work day, employee can: | Constantly (67-100%) | Frequently (33-66%) | Occasionally (0-33%) | Not at All |
|---|---|---|---|---|
| Climbing | ☐ | ☐ | ☐ | ☒ |
| Stand/Walk | ☐ | ☐ | ☒ | ☐ |
| Sit | ☐ | ☐ | ☒ | ☐ |
| Drive | ☐ | ☐ | ☒ | ☐ |
| Bend | ☐ | ☐ | ☒ | ☐ |
| Squat | ☐ | ☐ | ☒ | ☐ |
| Twist | ☐ | ☐ | ☐ | ☒ |
| Perform Work at Shoulder Level | ☐ | ☐ | ☒ | ☐ |
| Perform Repetitive Motions | ☐ | ☐ | ☒ | ☐ |
| Perform Overhead Work | ☐ | ☐ | ☐ | ☒ |

Employee is able to lift no more than: ☒ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: Will get MRI of Thoracic spine - continue PT

Physician Signature: Richard Jackson Date: 10/28/04

Time Out: 11:29 (AM) PM

# Redmond Occupational Health

# RETURN TO WORK FORM


Redmond FCC at Lindale
3138 Maple Road
Lindale, GA 30147
706-290-5000

Redmond FCC at Rockmart
2293 Rome Highway
Rockmart, GA 30153
770-684-0350

Redmond FCC at Shannon
5865 New Calhoun Highway, N.E.
Shannon, GA 30172
706-295-1184

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Rome, GA 30165
706-291-0291

Polk Medical Emergency Center
242 N. Main Street
Cedartown, GA 30125
770-748-2500


## Employer Information

Date: _____ ☐ Drug Screen ☐ Breath Alcohol

Date of Injury: 9/7/04

Employee Name: David Wilson SSN: _____

Company: GA. State Patrol Department: _____

Authorized by: _____ Title: _____ Time: _____

Telephone: _____ Fax: _____ Pager: _____

Description of Injury: Back Strain

Employee sent to: Redmond Family Care Center at West Rome
2304 Shorter Avenue
Rome, GA 30165

## Physician Information

Diagnosis: Back Pain / Spasm

Time In _____ AM PM

Treatment/Medications: _____

Estimated Return to Work Date: _____

**Work Status:** on 10/16 - 10/17/04

- ☐ No Restrictions — ~~As of:~~ _____
- ☑ See Physicial Capabilities Below — From: 10/18/04 To: after therapy
- ☐ Bed Rest — From: _____ To: _____
- ☐ MMI Achieved — As of: _____

**Re-check Date:** after Therapy

- ☐ No Follow-up Needed
- ☐ Workers' Comp Panel MD
- ☐ Specialist: Dr. _____ Date: _____ Time: _____
- ☑ Physical Therapy (RRMC-P.T.) Date: _____ Time: _____
- ☐ X-Ray / MRI / C.T. Date: _____ Time: _____ Location: _____

**PHYSICAL CAPABILITIES:**

| In an 8-12 hour work day, employee can: | Constantly (67-100%) | Frequently (33-66%) | Occasionally (0-33%) | Not at All |
|---|---|---|---|---|
| Climbing | ☐ | ☐ | ☑ | ☐ |
| Stand/Walk | ☐ | ☑ | ☐ | ☐ |
| Sit | ☑ | ☐ | ☐ | ☐ |
| Drive | ☐ | ☑ | ☐ | ☐ |
| Bend | ☐ | ☐ | ☑ | ☐ |
| Squat | ☐ | ☐ | ☑ | ☐ |
| Twist | ☐ | ☐ | ☑ | ☐ |
| Perform Work at Shoulder Level | ☑ | ☐ | ☐ | ☐ |
| Perform Repetitive Motions | ☑ | ☐ | ☐ | ☐ |
| Perform Overhead Work | ☐ | ☑ | ☐ | ☐ |

Employee is able to lift no more than: ☑ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: Worked 10/16/04 & 10/17/04
form runs 10/19/04 - is revised

Physician Signature: _____ Date: 10/18/04 10/19/04

Time Out: _____ AM PM

# Patient Referral

ADVANCE REHABILITATION


**CEDARTOWN**

1108 North Main Street
Cedartown, Georgia 30125
Phone: (770) 749-0250
Fax: (770) 749-0086

**ROME**

201 Turner McCall Blvd.
Rome, Georgia 30165
Phone: (706) 235-2727
Fax: (706) 235-2726

**CHATTOOGA**

11606 Highway 27
Summerville, Georgia 30747
Phone: (706) 857-6366
Fax: (706) 857-6372


Physical Therapy Appointment: Date _____ Time _____

Patient Name: David Wilson

Diagnosis: Back pain

Surgical Procedure: _____

☐ Consult: Evaluate & Treat

Precautions / Recommendations

resume previous PT
DC W/ recurrence

Frequency 2-3 / wk Duration x 2 wk

MODALITIES:

| | | |
|---|---|---|
| ☐ Heat / Cold | ☐ Transfers | ☐ Mckenzie Ex. |
| ☐ Electro-Stimulation | ☐ Balance | ☐ Body Mechanics |
| ☐ Ultrasound | EXERCISE: | ☐ Home Ex. Program |
| ☐ Massage | ☐ Passive ROM | ☐ F.C.E. |
| ☐ Other _____ | ☐ Active ROM | ☐ Work Hardening |
| TRAINING: | ☐ Resisted ROM | ☐ Traction |
| ☐ Gait | ☐ Spine Stabilization | ☐ Other |
| ☐ Fine Motor | | |

I certify that therapy services for the above named patient are required, medically necessary and authorized by me.

Next Appointment with Physician: _____

Physician Signature: _____ Date: 10/14/04

WMR 00009

**Redmond Occupational Health**

# RETURN TO WORK FORM


Redmond FCC at Lindale
3138 Maple Road
Lindale, GA 30147
706-290-5000

Redmond FCC at Rockmart
2293 Rome Highway
Rockmart, GA 30153
770-684-0350

Redmond FCC at Shannon
5865 New Calhoun Highway, N.E.
Shannon, GA 30172
706-295-1184

Redmond FCC at Trion
160 Central Avenue
Trion, GA 30753
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Redmond FCC at East Rome
715 E. 2nd Avenue
Rome, GA 30161
706-235-1102

Redmond FCC at West Rome
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706-233-4000

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188 E. Girard Avenue
Suite 104
Cedartown, GA 30125
770-749-1005

Redmond Emergency Center
501 Redmond Road
Rome, GA 30165
706-291-0291

Polk Medical Emergency Center
242 N. Main Street
Cedartown, GA 30125
770-748-2500


## Employer Information

Date: _____ ☐ Drug Screen ☐ Breath Alcohol

Date of Injury: 9/7/04

Employee Name: DAvid Wilson SSN: _____

Company: Ga State Patrol Department: _____

Authorized by: _____ Title: _____ Time: _____

Telephone: _____ Fax: _____ Pager: _____

Description of Injury: Back Strain

Employee sent to: Redmond Family Care Center at West Rome
2304 Shorter Avenue
Rome, GA 30165

## Physician Information

Diagnosis: Back Strain/Sprain

Time In _____ AM PM

Treatment/Medications: _____

Re-check Date: PRN

☐ No Follow-up Needed
☐ Workers' Comp Panel MD
☐ Specialist: Dr. _____
Date: _____ Time: _____
☑ Physical Therapy (RRMC-P.T.)
Date: _____ Time: _____
☐ X-Ray / MRI / C.T.
Date: _____ Time: _____
Location: _____

Estimated Return to Work Date: _____

**Work Status:**

☐ No Restrictions As of: _____
☑ See Physicial Capabilities Below From: _____ To: _____
☐ Bed Rest From: _____ To: _____
☐ MMI Achieved As of: _____

**PHYSICAL CAPABILITIES:**

| In an 8-12 hour work day, employee can: | Constantly (67-100%) | Frequently (33-66%) | Occasionally (0-33%) | Not at All |
|---|---|---|---|---|
| Climbing | ☐ | ☐ | ☑ | ☐ |
| Stand/Walk | ☐ | ☑ | ☐ | ☐ |
| Sit | ☑ | ☐ | ☐ | ☐ |
| Drive | ☐ | ☑ | ☐ | ☐ |
| Bend | ☐ | ☐ | ☑ | ☐ |
| Squat | ☐ | ☐ | ☑ | ☐ |
| Twist | ☐ | ☐ | ☑ | ☐ |
| Perform Work at Shoulder Level | ☑ | ☐ | ☐ | ☐ |
| Perform Repetitive Motions | ☑ | ☐ | ☐ | ☐ |
| Perform Overhead Work | ☐ | ☑ | ☐ | ☐ |

Employee is able to lift no more than: ☑ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: _____

Physician Signature: _____ Date: 12/14/04

WMR 00010

Time Out: _____ AM PM

DMS 53016573 (R 12/03)

# Advance Rehabilitation and Consulting, Inc.

115 Felton Drive
Rockmart, GA 30153

## Confidential Fax Cover Page

**Facsimile Transmission**
**Confidential Health Information Attached**

**THE DOCUMENTS ACCOMPANYING THIS TRANSMISSION CONTAIN CONFIDENTIAL HEALTH INFORMATION THAT IS LEGALLY PROTECTED. AS THE RECIPIENT OF THIS TRANSMISSION, YOU ARE OBLIGATED TO MAINTAIN IT IN A SAFE, SECURE AND CONFIDENTIAL MANNER.**

**Date:** 10-14-04 **Time:** 3:17

**To:** Dr. Meier

**Fax No:** 706-233-4006 **Phone No:** 706-233-4000

**Sender's Name:**

**Telephone No:** 678-757-1899 fax 678-757-1898

**Message:**

attn. Dr. Meier
Work Hardening Eval for David Wilson

**Number of pages transmitted [including cover page]:** 2

**Verification:** Please contact 678-757-1899 to verify the receipt of this facsimile.

# WORK HARDENING EVALUATION

Name David Wilson Diagnosis ~~SB~~ Back Strain DOI Sept 7, 2004
Date 10-14-04 Physician Meier Case Manager

## HISTORY

Age 47 Employer Georgia State Patrole Occupation/PDL Senior Troopers x 19½ Polk & Haralson Co.

Past Medical History out of work 5 wks. Carries 40 caliber Glock.
History Of Injury Was shocked with a taser. Hips went forward and shoulders back. Went to the ER and had 2 days and either a CT or MRI scan.
Pain & return to work. Hitting a dip in the rd. & pain. Cannot hold the gun into arm extension

Current Work Status Has worked 3 day.

## SUBJECTIVE

Complaints Report of significant ↑ in LB pain with bending, prolonged standing, and a lifting in a flexed position

## OBJECTIVE

**Occasional Lift:**
Floor to waist 12 lbs. Having pain that is continued from ~~W~~ SH-OH left.
Knuckle to shoulder 45 lbs. (L) thoracic discomfort and pulling sensation while lowering
Shoulder to overhead 20 lbs. Limited by (L) thoracic pain.
Carry 75→65 Unable to push wt. onto shelf due to pain. Has to use body to push box on to shelf (75 lbs.).
Safe

**Frequent Lift:**
FL-WA N/T Poor Mechanics
KN-SH 25 lbs. a little discomfort. 5:00.
SH-OH 10 lbs. 5:00 "Whole back is irritated. Pain in the left anterior rib cage region.

**Functional Activities:**
Simulation of tripode stance & gun: 3 lbs. unable to extend arms into firing position due to pain in the left thoracic region.
Simulation (Push-trunk in standing position): Break away weakness due to pain under the left shoulder blade.
Push/Pull 45 lbs. limited by (L) upper thoracic pain. 24/20 lbs. of force.

## ASSESSMENT

Ms. Wilson demonstrates limited strength with activities performed extended away from the body. The client does not able to achieve work postures, such as holding his gun extended, due to (L) upper thoracic pain.

Current Physical Demand Level Sedentary to Medium Heavy Duty

Goals (STG) ↑ FL-WA occ lift to 35 lbs.
(2) Demonstrate proper functional body mech
(3) ↑ SH-OH occ lift to 30 lbs.
(4) Tolerate gun stance with 2 lbs.

(LTG) (1) Demonstrate beg. lift from FL-WA with 25 lb
(2) ↑ KN-SH occ lift to 50 lbs.
(3) Tolerate gun stance & 3 lbs.
(4) Tolerate combat position & extension of resistance.

## Plan

Implement upper thoracic strength/conditioning thru ex. as well as general conditioning. W/ focus on strength/endurance in the extended reach position. Pt. will be educated on proper body mechanics and functional job aim. tasks will be added as tolerated.

Therapist Signature Sheri Russell MS, ATC

David Wilson

10/05/04 (Meier)

Date of Injury: 09/07

S: Markedly improved. Still a little tenderness. Therapy recommends work hardening. I agree. I want him to continue the medications to use on a p.r.n. basis. Try regular duty. Recheck in two weeks time.

EEM/ATI040

**Redmond Occupational Health**

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Suite 104
Cedartown, GA 30125
770-749-1005

Redmond Emergency Center
501 Redmond Road
Rome, GA 30165
706-291-0291

Polk Medical Emergency Center
242 N. Main Street
Cedartown, GA 30125
770-748-2500

# RETURN TO WO[illegible] FORM

## Employer Information

Date: 10/5/04 ☐ Drug Screen ☐ Breath Alcohol

Date of Injury: 9/7/04

Employee Name: David Wilson SSN: 260945083

Company: Ga State Patrol Department: _____

Authorized by: _____ Title: _____ Time: _____

Telephone: _____ Fax: _____ Pager: _____

Description of Injury: Back

Employee sent to: Redmond Family Care Center at West Rome
2304 Shorter Avenue
Rome, GA 30165

## Physician Information

Diagnosis: injured back
shoulder

Time In 950 AM PM

Treatment/Medications: _____

Estimated Return to Work Date: _____

**Work Status:**

- ☑ No Restrictions — As of: _____
- ☐ See Physicial Capabilities Below — From: _____ To: _____
- ☐ Bed Rest — From: _____ To: _____
- ☐ MMI Achieved — As of: _____

**Re-check Date:** 2wks 10-19-04

- ☐ No Follow-up Needed
- ☐ Workers' Comp Panel MD
- ☐ Specialist: Dr. _____ Date: _____ Time: _____
- ☐ Physical Therapy (RRMC-P.T.) Date: _____ Time: _____
- ☐ X-Ray / MRI / C.T. Date: _____ Time: _____ Location: _____

**PHYSICAL CAPABILITIES:**

In an 8-12 hour work day, employee can:

| | Constantly (67-100%) | Frequently (33-66%) | Occasionally (0-33%) | Not at All |
|---|---|---|---|---|
| Climbing | ☐ | ☐ | ☐ | ☐ |
| Stand/Walk | ☐ | ☐ | ☐ | ☐ |
| Sit | ☐ | ☐ | ☐ | ☐ |
| Drive | ☐ | ☐ | ☐ | ☐ |
| Bend | ☐ | ☐ | ☐ | ☐ |
| Squat | ☐ | ☐ | ☐ | ☐ |
| Twist | ☐ | ☐ | ☐ | ☐ |
| Perform Work at Shoulder Level | ☐ | ☐ | ☐ | ☐ |
| Perform Repetitive Motions | ☐ | ☐ | ☐ | ☐ |
| Perform Overhead Work | ☐ | ☐ | ☐ | ☐ |

Employee is able to lift no more than: ☐ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: try reg duty.
rec: light housekeeping x 1wk

Physician Signature: _____ Date: 10/5/04

Time Out: 1135 AM PM

WMR 00014

DMS 53016573 (R 12/03)

P MOND FAMILY CARE CENTER AT WEST R
2304 Shorter Avenue • Rome, Georgia 30165
706/233-4000

EDWARD E. MEIER, M.D.
Lic. # 043426

SHALINI G. REDDY, M.D.
Lic. # 045935

NAME David Wilson AGE

ADDRESS DATE 9/10/04

℞

J10XX 25 mg
1 PO q d #20
Lortab 5/500
1/2 q 4-6 h #20
Flexeril 10 mg
1 PO q HS #20

Refill _____ times
☐ Label

SIGNATURE

*To ensure brand name dispensing, prescriber must write 'Brand Necessary' or 'Brand Medically Necessary' on the prescription.*

RR-262 – CALDWELL-ROME

David Wilson

09/10/04 (Meier)

S: Follow-up on his back strain. He is somewhat better. He seems to have tolerated medications. He has some improvement. Minimal pain. A lot of spasms. Limited range-of-motion secondary to that.

A/P: We will go with a Toradol shot, given IM. We are going to try him on some physical therapy. Keep him on limited duty at work. Continue medications.

EEM/ATI040

FAXED

**Redmond Occupational Health**

Redmond FCC at Lindale
3138 Maple Road
Lindale, GA 30147
706-290-5000

Redmond FCC at Rockmart
2293 Rome Highway
Rockmart, GA 30153
770-684-0350

Redmond FCC at Shannon
5865 New Calhoun Highway, N.E.
Shannon, GA 30172
706-295-1184

Redmond FCC at Trion
160 Central Avenue
Trion, GA 30753
706-734-7302

Redmond FCC at East Rome
715 E. 2nd Avenue
Rome, GA 30161
706-235-1102

Redmond FCC at West Rome
2304 Shorter Avenue
Rome, GA 30165
706-233-4000

Redmond Internal Medicine at Cedartown
188 E. Girard Avenue
Suite 104
Cedartown, GA 30125
770-749-1005

Redmond Emergency Center
501 Redmond Road
Rome, GA 30165
706-291-0291

Polk Medical Emergency Center
242 N. Main Street
Cedartown, GA 30125
770-748-2500

# RETURN TO WO[illegible] FORM

## Employer Information

Date: 9/10/04 ☐ Drug Screen ☐ Breath Alcohol Date of Injury: 9-7-04

Employee Name: David Wilson SSN: 260-94-5083

Company: Ga State Patrol Department: _____

Authorized by: DOAS Title: _____ Time: _____

Telephone: _____ Fax: _____ Pager: _____

Description of Injury: _____

Employee sent to: Redmond Family Care Center at West Rome
2304 Shorter Avenue
Rome, GA 30165

## Physician Information

Diagnosis: Back pain/Sprain 20 to 40 yr

Time In 11:22 AM PM

Treatment/Medications: _____

Estimated Return to Work Date: _____

**Work Status:**

- ☐ No Restrictions As of: _____
- ☑ ~~See~~ Physicial Capabilities Below From: _____ To: _____
- ☐ Bed Rest From: _____ To: _____
- ☐ MMI Achieved As of: _____

**Re-check Date:** 2 wks

- ☐ No Follow-up Needed 9-24-04
- ☐ Workers' Comp Panel MD
- ☐ Specialist: Dr. _____ Date: _____ Time: _____
- ☑ Physical Therapy (RRMC-P.T.) Date: _____ Time: _____
- ☐ X-Ray / MRI / C.T. Date: _____ Time: _____ Location: _____

**PHYSICAL CAPABILITIES:**

In an 8-12 hour work day, employee can:

| | Constantly (67-100%) | Frequently (33-66%) | Occasionally (0-33%) | Not at All |
|---|---|---|---|---|
| Climbing | ☐ | ☐ | ☐ | ☐ |
| Stand/Walk | ☐ | ☐ | ☑ | ☐ |
| Sit | ☑ | ☐ | ☐ | ☐ |
| Drive | ☐ | ☐ | ☑ | ☐ |
| Bend | ☐ | ☐ | ☐ | ☑ |
| Squat | ☐ | ☐ | ☐ | ☑ |
| Twist | ☐ | ☐ | ☐ | ☑ |
| Perform Work at Shoulder Level | ☑ | ☐ | ☐ | ☐ |
| Perform Repetitive Motions | ☑ | ☐ | ☐ | ☐ |
| Perform Overhead Work | ☐ | ☐ | ☐ | ☑ |

FAXED

Employee is able to lift no more than: ☑ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

Comments: Sedentary duty @ WMR

Physician Signature: [signature] Date: _____

Time Out: 1:20 AM PM

WMR 00017

DMS 53016573 (R 12/03)

David Wilson

09/08/04 (Meier)

S: Back injury. He states he was shot by a taser as part of a training exercise and now with severe back pain and spasm and feels like he cannot straighten up. Seen at the ER in Forsyth and had x-rays done and sounds like had a CT or MRI. The patient does not like the pain meds because they make him hallucinate. He is only taking 1/2 a tablet. He is also on Robaxin 750. No previous history of medical problems of significance.

O: Vital signs are stable. Afebrile, nontoxic white male in no acute distress. HEENT exam: Unremarkable. Neck is supple. Back: Loss of lordosis. Excessive kyphosis. Bilateral spasms and tenderness. Urine did not show any mild ___.

A/P: We will obtain the records from the hospital. Give him a Toradol shot. Put him on some Vioxx. Switch him to Flexeril and the hydrocodone. May consider therapy. Off work until we recheck him.

EEM/atiap

**Redmond Occupational Health**

Redmond FCC at Lindale
3138 Maple Road
Lindale, GA 30147
706-290-5000

Redmond FCC at Rockmart
2293 Rome Highway
Rockmart, GA 30153
770-684-0350

Redmond FCC at Shannon
5865 New Calhoun Highway, N.E.
Shannon, GA 30172
706-295-1184

Redmond FCC at Trion
160 Central Avenue
Trion, GA 30753
706-734-7302

Redmond FCC at East Rome
715 E. 2nd Avenue
Rome, GA 30161
706-235-1102

Redmond FCC at West Rome
2304 Shorter Avenue
Rome, GA 30165
706-233-4000

Redmond Internal Medicine at Cedartown
188 E. Girard Avenue
Suite 104
Cedartown, GA 30125
770-749-1005

Redmond Emergency Center
501 Redmond Road
Rome, GA 30165
706-291-0291

Polk Medical Emergency Center
242 N. Main Street
Cedartown, GA 30125
770-748-2500

# RETURN TO WORK FORM

## Employer Information

Date: 9-8-04 ☐ Drug Screen ☐ Breath Alcohol Date of Injury: 9-7-04

Employee Name: David R Wilson SSN: _____

Company: GA State Patrol Department: Dpt. of Public Safety

Authorized by: DOAS Title: Snr. Trooper Time: 10am C'town

Telephone: 770-749-2200 Fax: _____ Pager: _____

Description of Injury: Back injury as a result of taser MX26

Employee sent to: Redmond Family Care Center at West Rome
2304 Shorter Avenue
Rome, GA 30165

## Physician Information

Diagnosis: Back pain / Sprain
2° to Taz

Time In _____ AM PM

Treatment/Medications: _____

Estimated Return to Work Date: _____

**Work Status:**

- ☐ No Restrictions — As of: _____
- ☐ See Physicial Capabilities Below — From: _____ To: _____
- ☐ ~~Bed Rest~~ — From: _____ To: _____
- ☐ MMI Achieved — As of: _____

**Re-check Date:** 2d.

- ☐ No Follow-up Needed 9-10-04
- ☐ Workers' Comp Panel MD
- ☐ Specialist: Dr. _____ Date: _____ Time: _____
- ☐ Physical Therapy (RRMC-P.T.) Date: _____ Time: _____
- ☐ X-Ray / MRI / C.T. Date: _____ Time: _____ Location: _____

**PHYSICAL CAPABILITIES:**

| In an 8-12 hour work day, employee can: | Constantly (67-100%) | Frequently (33-66%) | Occasionally (0-33%) | Not at All |
|---|---|---|---|---|
| Climbing | ☐ | ☐ | ☐ | ☐ |
| Stand/Walk | ☐ | ☐ | ☐ | ☐ |
| Sit | ☐ | ☐ | ☐ | ☐ |
| Drive | ☐ | ☐ | ☐ | ☐ |
| Bend | ☐ | ☐ | ☐ | ☐ |
| Squat | ☐ | ☐ | ☐ | ☐ |
| Twist | ☐ | ☐ | ☐ | ☐ |
| Perform Work at Shoulder Level | ☐ | ☐ | ☐ | ☐ |
| Perform Repetitive Motions | ☐ | ☐ | ☐ | ☐ |
| Perform Overhead Work | ☐ | ☐ | ☐ | ☐ |

Employee is able to lift no more than: ☐ 0-10 lbs. ☐ 10-25 lbs. ☐ 25+ lbs.

FAXED 9/8/04 @ 3:25pm to Kathy - occ med. 9/9 LCD

Comments: _____

Physician Signature: _____ Date: 9/8/04

WMR 00019

Time Out: 3:25 AM PM

DMS 53016573 (R 12/03)

RED ND FAMILY CARE CENTER AT WEST ROM
2304 Shorter Avenue • Rome, Georgia 30165
706/233-4000

**EDWARD E. MEIER, M.D.**
Lic. # 043426

**SHALINI G. REDDY, M.D.**
Lic. # 045935

NAME David Wilson AGE ____

ADDRESS ____ DATE 9/6/04

℞ Flexeril 10mg
1 PO q 6-8°
or spasm
#20

Refill ____ times
☐ Label

SIGNATURE ____

*To ensure brand name dispensing, prescriber must write 'Brand Necessary' or 'Brand Medically Necessary' on the prescription.*

RR-262 – CALDWELL-ROME

**Redmond Family Care Center**

**PATIENT EVALUATION**

| NAME (Last, First, MI) | DOB | AGE | SEX | DATE | TIME |
|---|---|---|---|---|---|
| Wilson David | 1-19-57 | 47 | M | 9-8-04 | 220 AM PM |

| WEIGHT | HEIGHT | TEMP | PULSE | RESP | B/P | INITIAL |
|---|---|---|---|---|---|---|
| | | | | | | EW |

PATIENT COMPLAINT ~~Backache~~ back injury hurts from shoulder
ONSET/DOI blade to midway down right side is worse than
HISTORY left - He was shot w/ 50,000 volt taser gun yesterday AM ⇒ then went to ER in Forsyth (Monroe Co. Hospital) Pain from shoulder blades down to lower back. No position provides relief. Does not like pain meds b/c they make him "see things"
CURRENT MEDICATION Methocarbam 750 mg, Oxycod/APAP-5-325mg Prevacid
PAST MEDICAL HISTORY
ALLERGIES NKDA

| FAMILY M.D. Tim Connor |
|---|
| LMP |
| PREGNANT? ☐ Yes ☐ No |
| TETANUS |
| SMOKING HX. |
| ETOH 4-5 beers a day |

**EXAMINATION**

| EXAM | WNL | ABN |
|---|---|---|
| HEENT | | |
| HEART | | |
| LUNGS | | |
| ABDOMEN | | |
| NEURO | | |
| GENITALIA | | |
| MS | | |
| SKIN | | |
| NECK | | |

**LABORATORY PROCEDURES**

| | | | |
|---|---|---|---|
| CBC | | GLUCOSE | |
| U/A | | CULTURE | |
| STREP | | PREG. TEST | |
| CHEM P | | OTHER | |

XRAYS: ☐ CHEST PA & LAT
☐ L/S SPINE ☐ OTHER

PHYSICIAN'S DIAGNOSIS

MEDICATIONS/SUPPLIES

TREATMENT Toradol 60mg IM
R hip CSI

INSTRUCTIONS

RECHECK ☐ PRN _____DAYS _____WKS _____MONTHS
NOTE FOR ☐ SCHOOL ☐ WORK _____DAYS

SIGNATURE

REFERRED TO

APPT. DATE/TIME

WMR 00021

DICTATED

# ERGENCY DEPARTMENT
# TERCARE INSTRUCTIONS

123040 RM- 119602 P/T-E/R
WILSON DAVID M 47
85 AYERS RD ARAGON , GA
ROGERS J
09/07/04 B/D 01/19/57

nroe County Hospital
syth, Georgia 31029
8-994-2521

he treatment you have received in the Emergency Department was an emergency treatment only, and is ot intended to be a substitute for or an effort to provide complete medical care. It is important that you ntact your physician for follow-up care, and that you report to him/her any new or remaining problems. is impossible to recognize and treat all elements of injury or illness in a single Emergency Department isit. Meanwhile, follow the instructions as listed below.

☐ The interpretation of your x-rays as given to you by the physician in the Emergency Room is only a preliminary report. The x-ray specialist reviews these films. If there is a change in the diagnosis, you and/or your physician will be notified. If you cannot be reached by phone, please call the E. D. after 11:00 a.m. the next working day for results.

☐ The medication you have been given may cause drowsiness. DO NOT drive or operate machinery.

☐ Please read and follow attached instructions given to you about: _____

☐ Additional Instructions: Rest Do not drive No strenuous activity. See your Dr as soon as possible. See Dr - return - or go to Emergency Room if worsen or new symptoms

by Dr. _____

☐ Call office to arrange an appointment to see your personal physician or Dr. Taunton at phone # 994-0437 in ____ days for follow-up care or sooner if needed or return to the E. D. as needed. as soon as possible.

I have received and understand the above instructions. I understand that I have had emergency treatment and that I may be released before all of my medical problems are known or treated. I will arrange follow-up care.

Patient/Responsible Party _____ Date 9/7/4 Nurse _____

ORIGINAL: GOES WITH PATIENT COPY: STAYS WITH CHART WMR 00022

Redmond
Occupational Health
**The Center of Attention**

*Phone: 706-290-8000*
*Fax: 706-236-1902*

***To:*** Sandra
***Fax#:*** 233-4006
***From:*** Kathy Bennett
***Date:*** 9/8/04
***Re:*** David Wilson
***Pages:*** 2

He is to be in at 2:00 p.m. to see Dr. Meier.

Thank You,
Kathy

***Thank you for your cooperation and assistance, we appreciate the opportunity to work with you. Please call us if we can assist you.***

| | | |
|---|---|---|
| Teresa Fagan, RN,COHN-S/CM<br>Director of Occupational Health | Marie Mitchell, RN,COHN-S/CM<br>Health Services Manager | Myra Bruce, RN, BSN<br>Clinical Coordinator |
| Kay Dixon, RN,BS,CWCP<br>Marketing Manager | Vanita Holden<br>Administrative Assistant | Gwen Rojas<br>Injury Care Coordinator |

STATE OF GEORGIA – DOAS
LISA – 404-463-3839

DAVID WILSON
DOB: 01/19/57
SS#: 260-94-5083
85 Ayers Road
~~Auburn~~, GA 30104
770-684-3305

VAGN

Date of Injury: 09/07/04

He was at Forsyth, Georgia in a training class. He was shot by a Taser Gun and felt pain all over his back and felt like he could not walk. He went to the Forsyth Hospital in an ambulance.

Lisa could not get a diagnosis from him. She would like for Dr. Meier to see him today at 2:00 p.m.

W/C Billing:
State of Georgia at DOAS
P. O. Box 38198
Atlanta, GA 30334

W/C Claim #: 05531736

# Redmond
# Family Care at West Rome

2304 Shorter Avenue
Rome, GA 30165
(706) 233-4000

**Patient Name:** Wilson, David **Patient ID:** 260-94-5083

**Date:** 9-8-04 **Time:** 3 00 **Collected by:** an

**Ordering Health Care Provider:** Meier

## Urinalysis:

Appearance clear
Color yellow
Glucose Θ
Bilirubin Small
Ketone trace
Specific Gravity 1.025
Blood Θ ✓
pH 6.0
Protein trace
Urobilinogen 1.0 ✓
Nitrite Θ
Leukocytes Θ

## Urine Microscopic Exam:

WBC _____ /HPF
RBC _____ /HPF
Epithelial Cells _____
Bacteria _____
Casts _____
Crystals _____
Trichomonas _____
Yeast _____

**Urine Culture** Ordered - Sent to _____

## Wet Mount / KOH:

Source _____
WBC _____
RBC _____
Epithelial Cells _____
Bacteria _____
Casts _____
Crystals _____
Trichomonas _____
Yeast _____

**Glucose (Accuchek)** _____
**H-Pylori** _____
**Influenza** _____
**Mono** _____
**Occult Blood** _____
**Sed Rate (ESR)** _____
**Strep** _____
**Tzanck** _____
**Urine Pregnancy** _____
**Other** _____

**Referred Test(s):**

**Comments:**

## Results Reviewed:

**Technician** an

**Physician** _____



DMS 53016561 R9/01

COOSA DIAGNOSTIC CENTER
16 Riverbend Drive Rome, Georgia 30161 Phone: 706/378-0611 Fax: 706/378-0143

Patient: WILSON, DAVID
SSN: 260945083 DOB: 1/19/1957
Physician: MICHAEL JACKSON
Exam Date: 11/9/2004 6:30:00 AM

Appointment ID: 0000048533

Study : MRI THORACIC SPINE WITHOUT CONTRAST, 11/9/04
Clinical History: MID THORACIC BACK PAIN, TRAUMA

TECHNIQUE: Sagittal T1 and T2 weighted images were obtained as were axial T2 weighted images.

FINDINGS: No prior similar studies are available for comparison.

Mild wedging of the T6 and T8 vertebral bodies is identified. This is associated with some superior end plate insufficiency as well as some mild anterior vertebral body compression. Some minimal marrow edema is seen to be associated with these injuries compatible with relatively acute trauma. There is some minimal loss of vertebral body height anteriorly.

No evidence for significant thecal sac or neural foraminal compromise is identified.

Axial images reveal no evidence for posterior element involvement. Some minimal surrounding soft tissue is identified at the T6 and T8 injuries which may represent some adjacent hematoma. Follow-up imaging may provide clarification.

IMPRESSION: Mild relatively acute appearing wedge compression deformities of the T6 and T8 vertebral with some probable surrounding soft tissue hematoma. No evidence for posterior element extension is identified. No evidence for significant thecal sac or neural foraminal compromise is seen.

TF/tk
Electronically signed by: THOMAS FARMER, MD 11/09/2004 01:32: PM

## PATIENT PHONE CALLS

MESSAGE FOR _____ URGENT ☐ Yes ☐ No

PATIENT'S NAME _____ DOB _____ WT _____

CALLER _____ HOME # _____ WORK # _____

PHARMACY _____ PHARMACY # _____

**MESSAGE**

David Wilson

MRI 11/9th - 6:00 AM

Coosa Diag.

OK Paula

**RESPONSE**

needs Rx faxed for MRI

Fax #

706-378-0143

DATE _____ TIME _____ BY _____

BY _____

DMS Form # 5301474 (R 12/99)

WMR 00027

COOSA
DIAGNOSTIC
CENTER
16 Riverbend Drive
Rome, Georgia 30161
706/378-0611 • Fax 706/378-0143

# RADIOLOGY OUTPATIENT ORDER FORM

**ATTENTION PATIENT:**
**You MUST bring this form with you to COOSA DIAGNOSTIC CENTER.**
**If you do not have this form, your Procedure will not be done.**

Only tests or Medicare Approved Panels that are medically necessary for the diagnosis or treatment of a Medicare or Medicaid patient will be reimbursed. Certain screening tests will not be reimbursed and should not be submitted for payment. The OIG states that a physician who orders medically unnecessary tests for which Medicare or Medicaid reimbursement is claimed may be subject to civil penalties under the False Claims Act.

## Patient Information

| | | |
|---|---|---|
| LAST NAME Wilson | FIRST NAME David | MI |
| Address | City | St. |
| Social Security No. 260-94-5083 | Birthdate 1-1957 | Sex X M ☐ F |
| Primary Ins. UHC | Pre-cert # | |
| GBHC # | Phone# | |

Note:

***Appointment***

**Date** 11-9- **Time** 6 AM.

## Medical Necessity Information

Sign, Symptom, or Diagnosis and ICD9 info required on all tests ordered.

| | Narrative Diagnosis | ICD9 Codes |
|---|---|---|
| 1. | Mid Thoracic BACK Pain | |
| 2. | | |
| 3. | | |
| 4. | | |

| Code Provided by | Code Received by | ABN Signed? |
|---|---|---|
| | | ☐ Yes ☐ No |

| X | CPT | MRI |
|---|---|---|
| | 70551 | MRI Brain (w/o contrast) |
| | 70553 | MRI Brain (with / w/o contrast) |
| | 70540 | MRI Face, Orbit, Neck |
| | 70336 | MRI TMJ |
| | 71550 | MRI Chest |
| | 72141 | MRI Cervical (w/o contrast) |
| | 72156 | MRI Cervical (with / w/o) |
| X | 72146 | MRI Thoracic (w/o contrast) |
| | 72157 | MRI Thoracic (with / w/o) |
| | 72148 | MRI Lumbar (w/o contrast) |
| | 72158 | MRI Lumbar (with / w/o) |
| | 72196 | MRI Pelvis |
| | 73220 | MRI Upper Extremity |
| | 73222 | MRI Shoulder Arth Rt Lt |
| | 73221 | MRI Shoulder Rt Lt |
| | 73221 | MRI Elbow Rt Lt |
| | 73221 | MRI Wrist Rt Lt |
| | 73720 | MRI Lower Extremity |
| | 73721 | MRI Ankle Rt Lt |
| | 73721 | MRI Knee Rt Lt |
| | 74181 | MRI Abdomen |
| | 70544 | MRA Head |
| | 70547 | MRA Neck |
| | 74185 | MRA Abdomen |
| | 73725 | MRA Femoral Art |
| | 75553 | MRI Cardiac |
| | 73225 | MRA Arm |
| | 76390 | MRI Spectroscopy |
| | 73718 | MRI Lower Ext. other than joint |
| | 73218 | MRI Upper Ext. other than joint |

| | CPT | MAMMOGRAPHY |
|---|---|---|
| | 76092 | Screening Bil. Mammogram |
| | 76091 | Diagnostic Bil. Mammogram |
| | 76090 | Diagnostic Mammogram Rt Lt |
| | 76090 | Additional View Mammogram |
| | 76091 | Implants - Bil. Mammogram |

| X | CPT | BONE DENSITY |
|---|---|---|
| | 76075 | Bone Density |

| X | CPT | CT |
|---|---|---|
| | 70450 | CT Head (w/o contrast) |
| | 70460 | CT Head (with contrast) |
| | 70470 | CT Head (with / w/o contrast) |
| | 70481 | CT Face, Orbit |
| | 70491 | CT Neck (with contrast) |
| | 71260 | CT Chest (with contrast) |
| | 72125 | CT Cervical (w/o contrast) |
| | 72126 | CT Cervical (with contrast) |
| | 72127 | CT Cervical (with / w/o) |
| | 72128 | CT Thoracic (w/o contrast) |
| | 72129 | CT Thoracic (with contrast) |
| | 72130 | CT Thoracic (with / w/o) |
| | 72131 | CT Lumbar (w/o contrast) |
| | 72132 | CT Lumbar (with contrast) |
| | 72133 | CT Lumbar (with / w/o) |
| | 72193 | CT Pelvis |
| | 73200 | CT Upper Extremity |
| | 73201 | CT Upper Extremity (contrast) |
| | 73700 | CT Lower Extremity |
| | 73701 | CT Lower Extremity (contrast) |
| | 74160 | CT Abdomen |
| | 70486 | CT Sinuses |
| | 76360 | CT Biopsy |
| | 76355 | CT Stereo Sinuses |
| | | CTA |
| | | Cardiac Scoring |

| X | CPT | ULTRASOUND |
|---|---|---|
| | 76536 | U / S Thyroid |
| | 76645 | U / S Breast Rt Lt |
| | 76700 | U / S Abdomen |
| | 76705 | U / S GB |
| | 76770 | U / S Renal |
| | 76805 | U / S Fetal Age |
| | 76830 | U / S Transvaginal |
| | 76856 | U / S Pelvis |
| | 93970 | U / S Venous flow Bilateral |
| | 93971 | U / S Venous flow Rt Lt |
| | 93978 | U / S Aorta |
| | 93880 | U / S Carotids |

| X | CPT | RADIOLOGY |
|---|---|---|
| | 71020 | Chest PA / Lat |
| | 71010 | Chest PA only |
| | 76000 | Chest Fluoro |
| | 74000 | KUB |
| | 74020 | Abdomen (flat and erect) |
| | 72040 | Cervical Spine AP / Lat |
| | 72050 | Cervical Spine 5 view |
| | 72052 | Cervical Flex-Exten |
| | 72040 | Cervical Spine obls only |
| | 72072 | Thoracic Spine AP / Lat |
| | 72100 | Lumbar Spine AP / Lat |
| | 72110 | Lumbar Spine 5 view |
| | 72114 | DYN 5 |
| | 72120 | Lumbar Flex-Exten |
| | 72090 | Scoliosis Survey |
| | 74246 | UGI |
| | 74220 | Barium Swallow |
| | 74249 | UGI and Small Bowel |
| | 74250 | Small Bowel |
| | 74400 | IVP |
| | 74270 | BE |
| | 73630 | Foot Rt Lt |
| | 73660 | Toes Rt Lt |
| | 73610 | Ankle Rt Lt |
| | 73590 | Tibia-fibula Rt Lt |
| | 73562 | Knee Rt Lt |
| | 73550 | Femur Rt Lt |
| | 73510 | Hip Rt Lt |
| | 72170 | Pelvis |
| | 73030 | Shoulder Rt Lt |
| | 73000 | Clavicle Rt Lt |
| | 73060 | Humerus Rt Lt |
| | 73080 | Elbow Rt Lt |
| | 73090 | Forearm Rt Lt |
| | 73110 | Wrist Rt Lt |
| | 73130 | Hand Rt Lt |
| | 73140 | Fingers Rt Lt |
| | 71100 | Ribs Rt Lt |
| | 71111 | Ribs -- Bilateral |
| | 70250 | Skull ap & lat |
| | 70220 | Sinuses |

| X | CPT | ARTERIAL FLOW STUDY |
|---|---|---|
| | 93923 | Arterial Flow Bilateral Leg |
| | 93922 | Arterial Flow Rt Lt Leg |
| | | Other: |

| X | CPT | NUCLEAR MEDICINE |
|---|---|---|
| | 78000 | Thyroid Uptake - single |
| | 78001 | Thyroid Uptake - multiple |
| | 78007 | Thyroid Imaging with Uptake |
| | 78010 | Thyroid Scan |
| | 78018 | Thyroid Mets. Whole Body |
| | 78075 | Adrenal Scan |
| | 78195 | Lymph Gland Scan |
| | 78205 | Liver Scan - spect |
| | 78215 | Liver / Spleen Scan |
| | 78216 | Liver / Spleen - vascular |
| | 78223 | Hepatobiliary Scan (Hidia) |
| | 78262 | Gastric Reflux Scan |
| | 78264 | Gastric Emptying Scan |
| | 78278 | GI Bleed Scan |
| | 78290 | Meckels Scan |
| | 78305 | Bone Scan - limited |
| | 78306 | Bone Scan - whole body |
| | 78315 | Bone Scan - 3 phase |
| | 78320 | Bone Scan - spect |
| | 78458 | Venous Flow Scan |
| | 78465 | Cardiac - Dip Thallium |
| | 78469 | Cardiac Infarct Scan |
| | 78473 | Cardiac Blood Pool |
| | 78580 | Lung Scan - perfusion |
| | 78585 | Lung Scan - vent & perfusion |
| | 78587 | Lung Scan - ventilation |
| | 78605 | Brain Scan |
| | 78606 | Brain with vascular flow |
| | 78607 | Brain - spect |
| | 78635 | CFS Study |
| | 62284 | Inj. for CFS Study |
| | 79000 | Thyroid Therapy |
| | 78709 | Renal Scan - function |
| | 78710 | Renal - spect |
| | 78802 | Tumor Local. Whole Body |

PHYSICIAN SIGNATURE: [signature] WMR 00028 DATE / TIME 11-8-04

**JOHNSON LAW**
*A Professional Corporation*
P. O. Box 48
CYNTHIA NOLES JOHNSON Cohutta, Georgia 30710 Phone: (706) 694-4298
TODD M. JOHNSON Downtown at 313 Wolfe Fax: (706) 694-3173
email: cindy@johnsonlawpc.com

October 24, 2006

Redmond Family Care Center
Attn: Medical Records
2304 Shorter Avenue
Rome, GA 30165

RE: ***David R. Wilson (DOB: 01/19/57; SSN: 260-94-5083)***

Dear Sir/Madam:

Enclosed herein you will find the Authorization for Disclosure of Protected Health Information on behalf of our client, **David R. Wilson**. I ask that you send copies of any and all medical records and reports that you have in your possession with regard to treatment rendered on Mr. Wilson's behalf since and including September 7, 2004. I would also ask that you send me a statement as to the total amount of expenses incurred by Mr. Wilson with Redmond Family Care Center.

If there are any charges for these copies, please send us a bill and you will be promptly paid.

Thank you for your time and consideration. Should you have any questions, do not hesitate to contact me.

Sincerely,

JOHNSON LAW, P.C.

By: Cynthia Noles Johnson
Cynthia Noles Johnson

Enclosure

11/9/06 - all records mailed - BA

# Patient Ledger

(RPT019)

HCA Enterprise (7)
REDMOND FAMILY CARE CENTER AT WEST ROME (579)
Data Refresh: 11/8/2006 10:41:30 AM

Betty Atkins
11/8/2006 12:07:47 PM
Request ID: 350598

## Current Patient Account Details

**Patient (Account):**
WILSON, DAVID (WC)

**Responsible Person:**
GEORGIA STATE PATROL, WC
1300 JOE FRANK HARRIS PKWY
CARTERSVILLE, GA 30120

**Daytime Phone:** (770)387-3703
**Last Payment Date:**
**Last Statement Date:**
**Patient Liability:** $0.00
**Last Patient Payment:** $0.00

**Superbill: 878045**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 11/16/04 | 11/16/04 | 99214 | $114.00 | 12/17/04 | Insurance Write Off | WC OF GA | 121704.b81549 | $37.00 |
| | | | | 12/17/04 | Insurance | WC OF GA | 121704.b81549 | $77.00 |
| 11/16/04 | 11/16/04 | J8499 | $14.00 | 12/17/04 | Insurance | WC OF GA | 121704.b81549 | $14.00 |

**Amount Billed:** $128.00 **Amount Paid:** $91.00 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $37.00 **Patient Liablity:** $0.00

**Superbill: 849901**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 10/28/04 | 10/28/04 | 99214 | $114.00 | 11/18/04 | Insurance Write Off | WC OF GA | 111704.b74963 | $24.00 |
| | | | | 11/18/04 | Insurance | WC OF GA | 111704.b74963 | $90.00 |
| 10/28/04 | 10/28/04 | J8499 | $59.00 | 11/18/04 | Insurance Write Off | WC OF GA | 111704.b74963 | $38.43 |
| | | | | 11/18/04 | Insurance | WC OF GA | 111704.b74963 | $20.57 |

**Amount Billed:** $173.00 **Amount Paid:** $110.57 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $62.43 **Patient Liablity:** $0.00

**Superbill: 812577**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 10/05/04 | 10/05/04 | 99213 | $73.00 | 10/29/04 | Insurance Write Off | WC OF GA | 102804.b70329 | $23.50 |
| | | | | 10/29/04 | Insurance | WC OF GA | 102804.b70329 | $49.50 |
| 10/05/04 | 10/05/04 | J8499 | $14.00 | 10/29/04 | Insurance Write Off | WC OF GA | 102804.b70329 | $1.40 |
| | | | | 10/29/04 | Insurance | WC OF GA | 102804.b70329 | $12.60 |

**Amount Billed:** $87.00 **Amount Paid:** $62.10 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $24.90 **Patient Liablity:** $0.00

**Superbill: 776909**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 09/10/04 | 09/10/04 | 99213 | $73.00 | 10/21/04 | Insurance Write Off | WC OF GA | 101904.b68179 | $23.50 |
| | | | | 10/21/04 | Insurance | WC OF GA | 101904.b68179 | $49.50 |
| 09/10/04 | 09/10/04 | J1885 | $70.00 | 10/21/04 | Insurance Write Off | WC OF GA | 101904.b68179 | $47.73 |
| | | | | 10/21/04 | Insurance | WC OF GA | 101904.b68179 | $22.27 |

**Amount Billed:** $143.00 **Amount Paid:** $71.77 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $71.23 **Patient Liablity:** $0.00

WMR 00030

# Patient Ledger

(RPT019)

HCA Enterprise (7)
REDMOND FAMILY CARE CENTER AT WEST ROME (579)
Data Refresh: 11/8/2006 10:41:30 AM

Betty Atkins
11/8/2006 12:07:47 PM
Request ID: 350598

## Current Patient Account Details

**Patient (Account):**
WILSON, DAVID (WC)
**Responsible Person:**
GEORGIA STATE PATROL, WC
1300 JOE FRANK HARRIS PKWY
CARTERSVILLE, GA 30120

**Daytime Phone:** (770)387-3703
**Last Payment Date:**
**Last Statement Date:**
**Patient Liability:** $0.00
**Last Patient Payment:** $0.00

**Superbill: 878045**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 11/16/04 | 11/16/04 | 99214 | $114.00 | 12/17/04 | Insurance Write Off | WC OF GA | 121704.b81549 | $37.00 |
| | | | | 12/17/04 | Insurance | WC OF GA | 121704.b81549 | $77.00 |
| 11/16/04 | 11/16/04 | J8499 | $14.00 | 12/17/04 | Insurance | WC OF GA | 121704.b81549 | $14.00 |

**Amount Billed:** $128.00 **Amount Paid:** $91.00 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $37.00 **Patient Liablity:** $0.00

**Superbill: 849901**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 10/28/04 | 10/28/04 | 99214 | $114.00 | 11/18/04 | Insurance Write Off | WC OF GA | 111704.b74963 | $24.00 |
| | | | | 11/18/04 | Insurance | WC OF GA | 111704.b74963 | $90.00 |
| 10/28/04 | 10/28/04 | J8499 | $59.00 | 11/18/04 | Insurance Write Off | WC OF GA | 111704.b74963 | $38.43 |
| | | | | 11/18/04 | Insurance | WC OF GA | 111704.b74963 | $20.57 |

**Amount Billed:** $173.00 **Amount Paid:** $110.57 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $62.43 **Patient Liablity:** $0.00

**Superbill: 812577**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 10/05/04 | 10/05/04 | 99213 | $73.00 | 10/29/04 | Insurance Write Off | WC OF GA | 102804.b70329 | $23.50 |
| | | | | 10/29/04 | Insurance | WC OF GA | 102804.b70329 | $49.50 |
| 10/05/04 | 10/05/04 | J8499 | $14.00 | 10/29/04 | Insurance Write Off | WC OF GA | 102804.b70329 | $1.40 |
| | | | | 10/29/04 | Insurance | WC OF GA | 102804.b70329 | $12.60 |

**Amount Billed:** $87.00 **Amount Paid:** $62.10 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $24.90 **Patient Liablity:** $0.00

**Superbill: 776909**

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 09/10/04 | 09/10/04 | 99213 | $73.00 | 10/21/04 | Insurance Write Off | WC OF GA | 101904.b68179 | $23.50 |
| | | | | 10/21/04 | Insurance | WC OF GA | 101904.b68179 | $49.50 |
| 09/10/04 | 09/10/04 | J1885 | $70.00 | 10/21/04 | Insurance Write Off | WC OF GA | 101904.b68179 | $47.73 |
| | | | | 10/21/04 | Insurance | WC OF GA | 101904.b68179 | $22.27 |

**Amount Billed:** $143.00 **Amount Paid:** $71.77 **Insurance Liablity:** $0.00
**Total Amount Due:** $0.00 **Amount Adjusted:** $71.23 **Patient Liablity:** $0.00





WMR 00031

# Patient Ledger

(RPT019)

HCA Enterprise (7)
REDMOND FAMILY CARE CENTER AT WEST ROME (579)
Data Refresh: 11/8/2006 10:41:30 AM

Betty Atkins
11/8/2006 12:07:47 PM
Request ID: 350598

**Superbill:** 773845

| From | To | Charge | Billed | GL Date | Type | Payer Name | Ref Number | Amount |
|---|---|---|---|---|---|---|---|---|
| 09/08/04 | 09/08/04 | 99204 | $188.00 | 10/04/04 | Insurance Write Off | WC OF GA | 93004.b62732 | $98.00 |
| | | | | 10/04/04 | Insurance | WC OF GA | 93004.b62732 | $90.00 |
| 09/08/04 | 09/08/04 | 81002 | $20.00 | 10/04/04 | Insurance | WC OF GA | 93004.b62732 | $20.00 |
| 09/08/04 | 09/08/04 | J1885 | $70.00 | 10/04/04 | Insurance Write Off | WC OF GA | 93004.b62732 | $46.40 |
| | | | | 10/04/04 | Insurance | WC OF GA | 93004.b62732 | $23.60 |
| 09/08/04 | 09/08/04 | J8499 | $28.00 | 10/04/04 | Insurance Write Off | WC OF GA | 93004.b62732 | $18.00 |
| | | | | 10/04/04 | Insurance | WC OF GA | 93004.b62732 | $10.00 |

**Amount Billed:** $306.00 **Amount Paid:** $143.60 **Insurance Liablity:** $0.00

**Total Amount Due:** $0.00 **Amount Adjusted:** $162.40 **Patient Liablity:** $0.00







WMR 00032

FORM 2

**NEW YORK LIFE INSURANCE COMPANY** 51 Madison Avenue, New York, N.Y. 10010
**NEW YORK LIFE INSURANCE AND ANNUITY CORP.** (A Delaware Corporation)
**NYLIFE INSURANCE COMPANY OF ARIZONA** (Not Licensed in Every State)

## *MEDICAL PROVIDER'S STATEMENT*

***(The patient is responsible for the completion of this form without expense to the Company)***

**Notice to Provider:** Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to the terms of his or her specific contract(s) with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.

1. PATIENT'S NAME: DAVID (First) RICHARD (Middle) WILSON (Last) DATE OF BIRTH: 01 (Month) / 19 (Day) / 1957 (Year)

2. CURRENT MEDICAL CONDITION(s):
   PRIMARY DIAGNOSIS: T6 + T8 Compression Fractures - secondary to Tazer. ICD-9-CM CODE: 805.2
   SECONDARY DIAGNOSIS: Reflux from Medications ICD-9-CM CODE: 530.81

3. DATE THAT SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED: 09 (Month) / ~~0807~~ EM (Day) 2004 (Year)

4. DATE THAT PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: 09 (Month) / 08 (Day) / 2004 (Year)

5. WAS PATIENT REFERRED TO YOU BY ANOTHER PRACTITIONER? YES ☐ NO ☒
   *(If "YES", please provide the name and address of that practitioner):* _____

6. HAS THE PATIENT EVER HAD THE SAME OR SIMILAR INJURY OR SICKNESS? YES ☐ NO ☒
   *(If "YES", please provide details and dates of treatment):* _____

7. HAVE YOU PREVIOUSLY TREATED THIS PATIENT? YES ☐ NO ☒ *(If "YES", provide diagnosis(es) and dates of prior treatment):* _____

8. OBJECTIVE FINDINGS *(Include x-ray, lab results and clinical findings. If pregnancy, also give LMP and EDC):* T6 AND T8 Wedge compression fracture of vertebral spine.

9. HAS PATIENT BEEN HOSPITALIZED? YES ☐ NO ☒ *(If "YES", provide reason, hospital name and dates of confinement):* _____

10. HAVE YOU COMPLETED CLAIM FORMS FOR OTHER INSURANCE CARRIERS? YES ☐ NO ☒
    *(If "YES", provide name of other insurance carrier(s)):* _____

11. NATURE OF TREATMENT CURRENTLY BEING PROVIDED OR PLANNED *(Include surgery and medications prescribed if applicable):* Unknown - Have not seen patient since 11/16/04.

CONTINUED ON NEXT PAGE



4/19/06 - mailed To: New York Life Ins. Co., Cleveland Service Center, Box 6916, Cleveland, Oh. 44101-BA

## MEDICAL PROVIDER'S STATEMENT
### (CONTINUED FROM PREVIOUS PAGE)

12. HAVE YOU REFERRED THE PATIENT TO ANOTHER PHYSICIAN OR PRACTITIONER? YES ☒ NO ☐
*(If "YES", please provide the name and address of all applicable physicians or practitioners):*
Dr. Scott Bowerman, Rome, Ga. - orthopedist

13. IN YOUR OPINION, IS THE PATIENT ABLE TO WORK AT THIS TIME? YES ☐ NO ☒
IF "NO", WHEN DO YOU EXPECT THAT THE PATIENT WILL BE ABLE TO PERFORM SOME WORK? Never / / (Month) (Day) (Year)

14. IS THERE ANY TYPE OF JOB MODIFICATION OR ACCOMMODATION THAT WOULD ENABLE THE PATIENT TO WORK AT THIS TIME? YES ☐ NO ☒ *(If "YES", please describe):* _____

15. BASED ON OBJECTIVE FINDINGS AND YOUR MEDICAL OPINION:
a.) THE PATIENT WAS UNABLE TO WORK FROM: ___/___/___ (Month/Day/Year) TO: ___/___/___ (Month/Day/Year)

b.) THE PATIENT WAS ABLE TO PERFORM SOME WORK FROM: ___/___/___ (Month/Day/Year) TO: ___/___/___ (Month/Day/Year)

16. LIST ALL CURRENT RESTRICTIONS AND LIMITATIONS YOU HAVE PLACED ON THE PATIENT'S WORK AND PERSONAL ACTIVITIES DUE TO THEIR MEDICAL CONDITION *(If none, indicate "NONE"):*
Numbers 15 + 16 - deferred to Dr. Bowerman.

17. IS THE PATIENT COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF THE PROCEEDS THEREOF? YES ☒ NO ☐

18. HAS THE PATIENT BEEN RELEASED FROM YOUR CARE? YES ☒ NO ☐

IF "YES", DATE THEY WERE RELEASED FROM YOUR CARE: 11 / 16 / 04 (Month/Day/Year)

IF "NO", DATE OF NEXT SCHEDULED TREATMENT OR EVALUATION: ___/___/___ (Month/Day/Year)

**ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

### MEDICAL PROVIDER'S DECLARATION AND SIGNATURE

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

| | | |
|---|---|---|
| Edward E. Meier, M.D. | 62-1662134 | 706-233-4000 |
| PHYSICIAN OR PROVIDER'S NAME (PLEASE PRINT) | TAX ID/SOCIAL SECURITY # | TELEPHONE NUMBER |
| 2304 Shorter Avenue | Edward E Meier | 4/18/2006 |
| Rome, Ga. 30165 | SIGNATURE OF PROVIDER | DATE SIGNED |
| STREET ADDRESS | | |

EMSI

CASE#: L544108-01
TEAM: 90
DESK: 9
DATE: 1/23/2006

# RECORDS REQUEST

RETURN FAX#:(866)839-5027

NAME: DAVID R WILSON
SSN: 260 94-5083
DOB: 1/19/1957
STATE: GA

INSURANCE BENEFITS PENDING

COMPANY: STANDARD INSURANCE-TEAM 17(LTD)
ACCT#: 006851
POLICY#: 00375568

281643-13905

FACILITY: EDWARD METER MD
ADDRESS: 2304 SHORTER AVE
CITY/ST: ROME, GA 30165
PH#: (706)233-4000

REQUESTER: SSTAUFFER
U/W TEAM:

**SPECIAL INSTRUCTIONS:** PLEASE RETURN THIS FORM WITH RECORDS
AGENT: JENNY VEDDER (503) 321-6614 , AGENCY: STANDARD INSURANCE CO, PLEASE SEND ALL MEDICAL RECORDS, CHART NOTES, OBJECTIVE FINDINGS, AND LAB RESULTS FROM SEPTEMBER 1, 2004 TO THE PRESENT. REQUE....(DRS MEIER AND JACKSON)

First date seen: 9-8-04 last date seen: 11-16-04

Please send *ONLY* records requested in the Special Instructions.
Please call before sending records due to company fee limit.

RETURN TO: P.O. BOX 2505
TEAM: 90

WACO TX 76702-2505
PHONE: (800)530-8705



1/23/2006 8:23:28 IDRPRTBUN 61389 90 9

WMR 00035

1/30/06 - all records mailed - BA

EMSI SM

lead and innovate



| | | | |
|---|---|---|---|
| To: | MEDICAL RECORDS | From: | DATACLAIMS TEAM 90 |
| Company: | EDWARD MEIER MD | Company: | EMSI |
| Fax: | 1-7062334006 | Fax: | 866-839-5027 |
| | | Phone: | 800-530-8705 |

Total Pages: 4 (Including this Cover Page)

Message:

Document generated for Transmission on 1/23/2006 at 8:23:28 AM.

Case#: L544108
Applicant Name: DAVID R WILSON

IF A FEE IS REQUIRED AND HAS NOT ALREADY BEEN PAID, PLEASE CALL BEFORE SENDING RECORDS DUE TO COMPANY'S FEE LIMIT

Sender: EMSI
Address: P.O. BOX 2505
WACO TX 76702-2505

Remarks: PLEASE FAX RECORDS TODAY.URGENT CLAIM IS PENDING.THANKS!!!

WMR 00036

EMPLOYEES' RETIREMENT SYSTEM OF GEORGIA

## SECTION 4 – EMPLOYEE DISABILITY INFORMATION INSTRUCTIONS

To be completed by Physician

This patient has applied for disability retirement. Your information is vital in determining the disability status for the job currently held. A job description is attached.

You have been named as a treating physician by this patient. We need a current evaluation. Please state specifically whether or not you determined that this patient is disabled for the current job held. The patient's signed authorization for release of any and all medical records will be found on page one of this form. Confidentiality will be maintained.

Document diseases, diagnoses, current condition, and prognosis and include copies of tests, office notes, blood tests and imaging reports for the past 18 months. Be sure to include any records that document and support the medical diagnosis, such as history, hospital admissions, operative notes, discharge summaries and referral reports.

Please bill the patient for any charges relating to this request.

If you need more space to answer these questions, please attach additional pages.

## Section 5 – PHYSICIAN / HOSPITAL / CLINIC CERTIFICATION

Please return this completed authorization and any attachments within 10 business days to the ERSGA office at the following address:

Mailed TO → 8/30/05 BA

Employees' Retirement System of Georgia
Two Northside 75, Suite 300
Atlanta, GA 30318-7778



WMR 00037